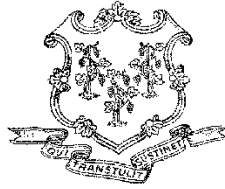


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Good Afternoon Senator Lesser, Representative Wood and members of the Insurance and Real Estate Committee. I would like to express my support for HB 6622, AN ACT CONCERNING PRESCRIPTION DRUG FORMULARIES AND LISTS OF COVERED DRUGS, SB 1045, AN ACT CONCERNING STEP THERAPY, ADVERSE DETERMINATION AND UTILIZATION REVIEWS, AND HEALTH INSURANCE COVERAGE FOR CHILDREN, STEPCHILDREN AND OTHER DEPENDENT CHILDREN, SB 1049, AN ACT CONCERNING HIGH DEDUCTIBLE HEALTH PLANS, HB 6626, AN ACT CONCERNING REQUIRED HEALTH INSURANCE AND MEDICAID COVERAGE, AMBULANCE SERVICES AND COST TRANSPARENCY, and SB 1048, AN ACT CONCERNING REIMBURSEMENTS FOR CERTAIN COVERED HEALTH BENEFITS.

I am pleased to again be working with my friend former state senator Len Fasano on some of these issues. Len and I had a long partnership on healthcare reform which I believe has created many meaningful protections for patients and improvements to our healthcare system. I believe he will also be testifying for some of the issues on the agenda today.

HB 6622 would protect patients from formulary changes during their policy terms. It is simply unfair that if a patient buys a health insurance policy that includes prescription drug coverage for a specific drug that the health insurer can change the formulary during the policy term and exclude that drug. There are times when a physician and a patient knowingly choose a drug that has some documented dangerous side effects because despite these dangers it appears to be the best course of treatment for that patient. And, of course, an insurer could contact a physician to share any safety concerns it had rather than denying coverage as a first step.

SB 1045 would provide a number of innovative protections for patients. First, it would create a presumption that treatment that is ordered by a physician is medically necessary treatment. This would allow physicians to practice medicine and limit the ability of the health insurers to interfere with patient treatment by making medical decisions which they are not qualified to make.

Generally in law, the burden of proof in any case is placed on the party who has the relevant information and knowledge. SB 1045 would bring appeals of adverse determinations in line with most areas of the law. Here, the insurer is the only party with knowledge as to why a claim was denied. In appeals of adverse determinations, neither the patient nor the provider know why the payer declined to cover a service.

Despite this reality, under the current framework the burden of proof in these appeals is on the patient and the provider. In fact prior to PA 12-102 the patient and provider didn't even have the right to access the record that the insurer used to make the decision. In addition, an insurer is not licensed to practice medicine and its judgment as to what is medically necessary for a patient should hold far less weight than that of the treating physician. The insurer could still, of course, deny claims under this framework; it would simply have to prove that the treatment was

not medically necessary. In addition, if an insurer has concerns about the treatment practices of an in-network provider, that concern should be addressed with the provider; the patient should not be used as a pawn in these disputes.

SB 1045 would also strengthen patient protections vis a vis insurers use of step therapy. While there are legitimate uses of step therapy, too often it is implemented in a manner that interferes with patient care and leads to insurers preventing physicians from providing the best care for patients. I am pleased that protections in the bill this year apply to behavioral health as well as chronic diseases. In 2014 Public Act 14-118 AN ACT CONCERNING REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY created certain patient protections regarding insurance carriers' use of step therapy. However, patients and providers continued to have situations in which the carriers' step therapy policies prevent the patients from receiving the treatment that their health care providers have decided is the most appropriate. In some cases this has delayed effective treatment which can leave patients with diminished health outcomes. In 2017 PA 17-228, AN ACT CONCERNING STEP THERAPY FOR PRESCRIPTION DRUGS PRESCRIBED TO TREAT STAGE IV METASTATIC CANCER, recognized these continued patient struggles and further regulated the use of step therapy in certain cancers. However, the use of step therapy continues to be particularly problematic for chronic disease, behavioral health and cancer patients. SB 1045 would ensure that the physician is able to provide the best treatment for patients.

In addition, SB 1045 would create a more stringent definition of "clinical peer" in the appeal process for adverse determinations (including in the peer to peer conference that the health carrier is required to offer to the treating physician upon the initial adverse determination). Requiring that the clinical peers used to evaluate adverse determination reviews be certified

specialists in the same subspecialty would result in more accurate and appropriate determinations. This legislation also would require that the peer that is provided for the peer to peer conference have the authority to overturn the adverse determination. This would benefit all parties involved and make our healthcare system more effective.

Finally, SB 1045 would require that children be allowed to remain on their parents' policies through the end of the year in which the child turns 26. I believe that some insurers already do this and this requirement would level the playing field and alleviate stress for policy holders who would otherwise have to scramble to find insurance mid-year.

Passing SB 1045 would provide much needed and sensible reforms to our healthcare system.

SB 1049 simply requires that high deductible health plans calculate the deductible on a calendar year basis. This would prevent patients who have to change plans mid-year from having to meet the deductible twice.

HB 6626 includes a variety of coverage requirements which I support as well as patient protections regarding ambulance billing. The issue of ambulance surprise billing is a complicated one which few states have been able to address. I applaud the inclusion of this language in HB 6626 and I look forward to working with you on this extraordinarily important matter.

SB 1048 would establish site neutral payment policies for certain services in Connecticut. SB 811 (PA 15-146) originally had contained a provision to create site neutral payment policies between physician owned practices and hospital owned outpatient practices. The site neutral reimbursement provision was ultimately removed in order to facilitate passage of the bill. The disparity in pricing for the same procedure at different sites of service goes beyond any rational explanation. For example, an infusion of the drug Tysabri is billed at \$6700 and reimbursed at \$6400 at an independent infusion center while one Connecticut hospital bills at \$33,000 and is paid \$12,000 while another Connecticut hospital bills \$37,000 and is paid \$16,000. This is for the same infusion for the same drug. There are a variety of ways to move toward site neutral payment policies and I would be pleased to work with you on them.

Thank you for hearing these innovative and important bills